STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010885	A. BUILDING: _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00162718. Complaint IN00162718 - Substantiated. No deficiencies related to the allegations are cited. Survey Date: January 29, 2015 Facility Number: 010885 Provider Number: 010885 AIM Number: NA Survey Team: Gloria J. Reisert, MSW, TC Census bed type: Residential: 104 Total: 104 Census payor type: Other: 104 Total: 104 Sample: 03 Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the investigation of Complaint IN00162718. Quality Review 01/30/15 by Lisa McColly	R 000		